Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INJURY ONE TREATMENT CENTER
5931 DESCO DR
DALLAS TX 75225

Respondent Name
DEEP EAST TEXAS SELF INSURANCE

Carrier's Austin Representative Box
Number 44

MFDR Tracking Number
M4-13-0413-01

MFDR Date Received
October 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…The insurance company denied stating based on the findings of a review organization. Per rule 134.600(a) states that the carrier is liable for the reasonable and necessary medical costs relating to treatments/service which require preauthorization if the carrier gave preauthorization prior to the services being rendered."

Amount in Dispute: $369.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to this medical fee dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2011	96101 $54.54 ÷ 33.9764 x $81.76 x 2 hours = $262.49.	$369.39	$262.49

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 defines the health care that requires preauthorization.
3. 28 Texas Administrative Code §133.240 describes medical payments and denials
4. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)

- 216 – based on the findings of a review organization
- This procedure on this date was previously reviewed.
- 18 – duplicate claim/service

Issues

1. Did the respondent support its denial reason of "216 - based on the findings of a review organization."?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.240(b) states that for health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized. The insurance carrier's denial of "216 - based on the findings of a review organization" is not supported. A review of the medical documentation submitted by the requestor supports that preauthorization was requested according to 28 Texas Administrative Code §134.600 for three hours psychological testing with CPT code 96101; however only two hours of psychological testing was approved with Pre-Authorization number 42575 dated November 7, 2011. The insurance carrier's denial of "216 - based on the findings of a review organization" is not supported.

2. 28 Texas Administrative Code §133.305(a)(5) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes). 28 Texas Administrative Code §134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…(2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   CPT code 96101 is defined as "psychological testing…per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report." A review of the submitted report indicates 2.75 hours time spent; only two hours was preauthorized.

   Reimbursement is calculated as follows: $54.54 DWC conversion factor ÷ 33.9764 Medicare conversion factor x $81.76 participating amount = $131.24 x 2 hours = $262.49 (MAR).

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $262.49.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $262.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.